APPENDIX B

MENTAL HEALTH AND SUBSTANCE ABUSE COVERAGE

The provisions of this Appendix B apply to enrollees of the Comprehensive Health Savings Plan (CHSP),Basic Medical Plan, Enhanced Medical Plan, and Point of Service options of the Program.

I. Definitions

To the extent they are not in conflict with the following, definitions in Appendix A are incorporated herein by reference. For purposes of this Appendix:

A. "approved mental health or substance abuse treatment program and/or provider" means an inpatient or outpatient program and/or provider which/who provides medical and other services to enrollees for a mental health or substance abuse condition, meets all state licensure and approval requirements, and has entered into an agreement with the coverage carrier to provide services as specified in this Appendix.

B. "assessment" means

1. determination by an assessment coordinator of the nature of the enrollee's condition (mental health and/or substance abuse), the need for treatment, the type of treatment required and referral to the most appropriate level of care; and

2. for a substance abuse patient, the development of a continuing care treatment plan by the enrollee, the assessment coordinator, and the attending physician, if appropriate.

C. "assessment coordinator" means a qualified employee of a central diagnostic and referral agency (CDR) which has been selected and approved to provide assessment services. Assessment coordinators must meet Program standards for selection.

D. "central diagnostic and referral agency" or "CDR" means an approved agency which employs assessment coordinators designated to: make all contractually-mandated face-to-face assessments for the development of substance abuse continuing care treatment plans;

make determinations regarding whether the patient's condition requires mental health and/or substance abuse treatment; make referrals to panel providers; provide short-term counseling (up to two visits per enrollee); and perform aftercare planning and follow-up. The CDR may provide up to three short-term counseling sessions for employees, and may communicate with Employee Assistance Program representatives about assessment and referral activities relating to an employee (when appropriate and when authorized by the employee). The CDR will supply necessary information to the carrier about panel provider performance and selection and other utilization data and statistics as required, including evaluations using designated performance data of panel providers with whom the carrier contracts.

Effective January 1, 2001, CDR's will no longer be utilized under this Appendix B. All the functions and the responsibilities of the CDR will be transferred on January 1, 2001 and performed by the central review organization (CRO) or a qualified designee of the CRO.

E. "central review organization" or "CRO" means a national organization which has been designated to provide the following functions:

1. confirm eligibility of the patient for mental health and/or substance abuse coverage under the Program;

2. authorize and approve inpatient and outpatient mental health treatment, outpatient substance abuse treatment and outpatient psychological testing;

3. re-credential panel providers;

4. monitor CDR performance;

5. exercise managed care protocols, with CDR assistance when appropriate, for those enrollees who require both mental health and substance abuse outpatient visits; and

6. evaluate panel providers and make contracting recommendations to the carrier, using designated performance standards.

F. "clinical nurse specialist" means a person who meets all of the following criteria:

1. possesses a Master of Arts (MA), Master of Science (MS) or Master of Science in Nursing (MSN) degree from an accredited school of nursing. (The master's degree must be in psychiatric nursing or the individual must be eligible for listing in the American Nursing Association Register of Certified Nurses in Advanced Practice as a clinical specialist in Adult Psychiatric Mental Health Nursing, or Child/Adolescent Psychiatric Nursing);

2. has a minimum of five years post-master's degree clinical experience in the field of psychiatric mental health nursing, at least two of which were supervised by a master's level psychiatric nurse (or the equivalent);

3. possesses a license as a Registered Nurse in the jurisdiction in which the practice is to occur;

4. possesses a minimum professional liability coverage of $1 million per occurrence and $1 million aggregate (unless there are state statutes which modify the malpractice requirements in such states); and

5. has signed an agreement with the carrier to participate as a panel provider.

G. "continuing care treatment plan" means a document completed for substance abuse patients by an assessment coordinator at the conclusion of the assessment process. The continuing care treatment plan includes the recommended provider(s), and the type(s) and duration of treatment, and may be modified by the provider and the assessment coordinator in consultation during the course of treatment.

H. "detoxification" means treatment for the physiologic stabilization of an enrollee who is undergoing acute withdrawal from an intoxicating substance. To be covered under this Program, such treatment must be provided by, or under the supervision of, a physician and through a facility approved to provide such care.

I. "detoxification facility" means a hospital or residential treatment facility which is a provider of detoxification services. Such facilities may offer substance abuse rehabilitation treatment subsequent to detoxifying an enrollee.

J. "halfway house treatment" means treatment provided under a semi-residential living arrangement to a substance abuse patient who requires a more structured living environment than outpatient treatment or partial hospitalization treatment would provide, but who does not require full-time residential treatment and care. It provides a controlled environment during the hours of the day the enrollee is not undergoing treatment or is not engaged in specific constructive activity (e.g., working or attending school).

K. "inpatient care" means treatment in:

1. a hospital;

2. a detoxification facility; or

3. a residential care facility.

L. "mental disorder" means any mental, emotional, or personality disorder classified as a mental disorder in categories 290.0 through 319.0 of the most recent edition of the "International Classification of Diseases, 9th Revision, Clinical Modification" excluding alcohol and drug abuse as classified in categories 303.0 through 305.9 (see subsection IV.H., below).

M. "outpatient facility" means an administratively distinct governmental, other public, private, or independent unit or part of such unit that provides outpatient mental health or substance abuse services.

The term includes centers for the care of adults or children such as hospitals, clinics, and partial hospitalization centers. For mental health services, the definition includes Community Mental Health Centers as defined in the Federal Community Mental Health Centers Act of 1963, as amended.

N. "outpatient treatment" or "visit" (including intensive outpatient treatment) means a therapy session provided in an outpatient mental health or substance abuse treatment facility or by an individual mental health or substance abuse provider. All sessions between an individual patient and a provider in a single day, with a total duration of four hours or less, are considered to be a single treatment or visit. If outpatient sessions with all providers in a given day

total more than four hours, such treatment shall be considered partial hospitalization.

O. "panel provider" means a mental health or substance abuse provider who has been selected and has agreed to provide services in accordance with the terms of participation established by the Program and has executed an agreement with the carrier.

P. "partial hospitalization treatment" means a semi-residential level of care for patients with mental health or substance abuse disorders who require coordinated, intensive, comprehensive and multidisciplinary treatment in a structured setting, but less than full-time hospitalization. The patient undergoes therapy for more than four (4) hours a day, and may receive additional services (e.g., meals, bed, recreation);

Q. "psychiatrist" means a physician who is board eligible or board certified in psychiatry and licensed to practice medicine at the time and place services are rendered or performed.

R. "psychologist" means a person who possesses a doctor of philosophy (Ph.D.), doctor of education (Ed.D.), doctor of mental health (DMH), or doctor of psychology (PsyD) degree from a regionally accredited university, has a minimum of five years of post-doctoral clinical experience (at least two of which were supervised by a licensed clinical psychologist or by a board-qualified psychiatrist), possesses a valid license for the independent practice of psychology at the highest level recognized by the state in which practice is to occur, is eligible for listing in the National Register of Health Care Providers in Psychology, and participates as a panel provider.

S. "registration" means contact by the provider with the CRO to inform the agency that the enrollee is commencing a course of mental health or substance abuse treatment, to confirm eligibility under the Program, and to obtain any necessary approvals or authorizations.

T. "residential care facility" means an approved inpatient facility which operates 24 hours a day, seven days a week for the provision of residential mental health and/or substance abuse treatment.

U. "social worker" means a person who possesses a master in social work (MSW), master of science in social work (MSSW), or doctor of social work (DSW) degree from a graduate school of social work accredited by the Council on Social Work Education, has a minimum of five years of post-masters or post-doctoral degree clinical social work experience (at least two of which were supervised by a licensed clinical social worker), possesses a valid license or certificate for the independent practice of social work at the highest level recognized by the state in which practice is to occur, is eligible for listing in the National Association of Social Work Register of Clinical Social Workers and/or the National Register of Mental Health Care Providers in Social Work, and participates as a panel provider.

V. "substance abuse" means alcohol or drug dependence as classified in categories 303.0 through 305.9 (excluding 305.1 and 305.9) of the most current edition of the "International Classification of Diseases, 9th Revision, Clinical Modification" (see subsection IV.H., below).

II. Terms and Conditions of Coverage

A. Conditions of Benefit Payment

An enrollee is eligible for benefits for covered expenses incurred during an approved course of treatment only if the following conditions or requirements are met:

1. Services must be provided on or after the enrollee's effective date of coverage under the Program and this Appendix.

2. Benefits must be available within the benefit period (see II.B., below).

3. a. In order to be covered up to the benefit maximum under the Program, all covered services rendered in the care and treatment of mental health and substance abuse related disorders must be delivered by panel providers, except in the case of emergency which is subject to the provisions of Section IV.B. of this Appendix. The panel may be comprised of the following types of facilities and providers:

(1) Hospitals

(2) Outpatient facilities

(3) Detoxification facilities

(4) Residential care facilities

(5) Partial hospitalization facilities

(6) Halfway houses

(7) Skilled nursing facilities

(8) Psychiatrists

(9) Psychologists

(10) Social workers

(11) Clinical nurse specialists

(12) Outpatient clinics

b. In addition, if due to the unavailability of specialized services, the enrollee must be referred to a non-panel provider, then, in such cases only, non-panel providers will be covered up to the benefit maximum subject to App. B, II.B.4.a. and b., provided the enrollee is referred by the CRO or a panel provider and the services are authorized, in advance, by the CRO.

c. Services provided in accordance with App. B, IV.B.3. are covered up to the benefit maximum.

4. Outpatient treatment by clinical nurse specialists, social workers or psychologists as independent practitioners must be rendered by participating panel providers.

5. In order to be eligible for benefits for residential and/or halfway house substance abuse treatment, the enrollee must be assessed by an assessment coordinator from a designated CDR. Expenses for days of treatment during an admission to a residential treatment facility or halfway house program will not be covered prior

to the time assessment and a treatment plan are obtained from a substance abuse assessment coordinator. If such coordinator makes a determination of substance abuse and the assessment specifies a level of care which includes residential or halfway house treatment, such treatment will be covered subject to other Program provisions.

6. Detoxification admissions must be reported to the CRO within 24 hours of admission. In such cases, the CRO will notify the CDR assigned to that location. The CDR's assessment coordinator will contact the enrollee during or after the detoxification and develop a plan for treatment subsequent to detoxification (continuing care treatment plan). Detoxification confinements longer than three days must be approved by the CDR or CRO.

7. Mental health inpatient services and admissions must be authorized by the CRO within 24 hours of admission.

8. Partial hospitalization treatment and outpatient mental health and substance abuse treatment must be registered with the CRO. This procedure does not apply to day, night or outpatient treatment services rendered as part of an authorized substance abuse continuing care treatment plan.

9. Admission to a skilled nursing facility must be for the treatment of a mental health condition, must be authorized by the CRO and must immediately follow a confinement for the same condition.

10. Benefits are payable subject to the provisions and limitations of the Program, regardless of the treatment plan developed through assessment.

11. Benefits payable under this Appendix for an enrollee eligible for Medicare shall be paid in accordance with the terms and conditions pertaining to Medicare as specified in App. A, II.E.

B. Benefit Period

1. a. An enrollee is eligible for a maximum of 45 days of covered inpatient mental health care

within the benefit period set forth in App. A, II.B.1.

b. An enrollee is eligible for a maximum of 45 days of covered inpatient substance abuse care including detoxification within the benefit period set forth in App. A, II.B.1.

c. Each day of care utilized for inpatient substance abuse treatment is charged against the unused portion of the 45-day inpatient mental health benefit period. Likewise, each day of inpatient mental health care is charged against the unused portion of the 45-day inpatient substance abuse treatment period.

2. a. An enrollee is eligible for a maximum of 90 days of care in a partial hospitalization treatment facility within the benefit period set forth in App. A, II.B.1.

b. Each day of inpatient care for mental health or substance abuse treatment reduces by two the number of days of care available for mental health or substance abuse partial hospitalization treatment. Each two days of partial hospitalization treatment reduces by one the number of days of care available for inpatient care.

3. a. An enrollee is eligible for a maximum of 90 days of mental health care in an approved skilled nursing facility within the benefit period set forth in App. A, II.B.1.

b. Each day of inpatient care for mental health treatment within the benefit period reduces by two the number of available days for skilled nursing facility care. Each two days of medical care for the treatment of mental disorders in a skilled nursing facility reduces by one the number of days of inpatient medical care available for the treatment of mental health related disorders in a hospital.

4. a. An enrollee is eligible for 20 outpatient mental health visits at 100% coverage and an additional 15 visits at 75% coverage for outpatient mental health treatment for both

facility and professional services per calendar year.

b. An enrollee is eligible for 35 outpatient substance abuse visits at 100% coverage for both facility and professional services per calendar year.

c. When an enrollee requires mental health and/or substance abuse outpatient treatment, the CRO and/or CDR (where appropriate) shall exercise managed care protocols after a total of six outpatient visits and shall monitor the treatment plan(s) to assure appropriate coordinated care.

(1) Inpatient substance abuse care assessments, referrals and continuing care treatment follow-up by CDRs are mandatory and do not reduce the enrollee's outpatient visit entitlement.

(2) Voluntary utilization of the CDR for outpatient mental health or substance abuse assessment and referral does not count as an outpatient visit.

d. Anorexia nervosa, bulimia and other conditions covered by Appendix B which are appropriate for case management, may be case managed by the CRO utilizing the case management procedures described in App. A, III.K. with any alternative benefit plan being limited to the dollar pool created using the 45-day inpatient benefit described in this section.

e. Outpatient psychological testing is not considered "treatment" and is not charged against the outpatient visit maximum.

f. Each visit by one or more members of an enrollee's family for family counseling counts as one visit applicable to the enrollee's annual outpatient treatment maximum.

5. An enrollee shall be eligible for a lifetime maximum of 90 days of substance abuse treatment in a panel halfway house.

6. A new benefit period begins only when the enrollee has been out of care (as described below) for a continuous period of 60 days. Accordingly, there must be a lapse of at least 60 consecutive days between the date of the enrollee's last discharge from any hospital, skilled nursing facility, residential care facility or any other facility to which the 60-day benefit renewal period of this Appendix and Appendix A apply (see App. A, II.B.3. for example), and the date of the next admission, irrespective of the reason for the last admission and irrespective of whether or not benefits are paid as a consequence of such admission. Further, if subsequent to such discharge, the enrollee is a patient in a psychiatric or substance abuse partial hospitalization care program, a substance abuse halfway house, a hospice program or is receiving home health care visits, the 60-day renewal period is broken, whether or not benefits are paid as a result of receipt of such services.

C. Non-Completion of the Substance Abuse Treatment Plan by an Employee

Employees entering detoxification, residential or halfway house treatment facilities are required to receive a continuing care treatment plan from the assessment coordinator as part of the assessment process. Non-completion of the portions of such treatment plan which are covered services (including outpatient and partial hospitalization programs) will result in the following actions being taken:

1. The carrier will send a letter to the employee and to the Corporation's Medical Director notifying them of the failure to complete the treatment plan.

2. The letter will notify the employee that if a second continuing care treatment plan is established and not completed, a maximum of up to a $500 overpayment will have occurred as a result of medical expenses incurred on the employee's behalf.

3. If the employee fails to complete a second continuing care treatment plan, the carrier will notify the employee and the Corporation's Medical Director of such failure and of any overpayment. The provisions of Article I, Section 9, of the Program will apply.

However, if the employee establishes to the satisfaction of the Corporation's Medical Director that such employee is motivated towards recovery and that the treatment plan was discontinued for a satisfactory reason, then such overpayment will not have occurred.

4. For each subsequent non-completion of a treatment plan, the maximum overpayment amount will increase in increments of $250, up to a maximum overpayment amount of $1,000 for each occurrence.

III. Coverages

A. Inpatient Care (Mental Health and Substance Abuse)

1. Inpatient mental health and substance abuse care is subject to the benefit period set forth in App. B, II.B.1.

2. Inpatient services by non-panel providers are subject to the provisions of Sections IV.B.2. (for mental health treatment) and IV.B.4. (for substance abuse treatment) of this Appendix.

3. Coverage includes the following inpatient services when provided and billed by the facility:

a. semiprivate room, including general nursing services, meals and special diets;

b. laboratory and pathology examinations related to the treatment received in the facility;

c. drugs, biologicals, solutions and supplies related to the treatment received and used while the enrollee is in the facility;

d. supplies and use of equipment required in the care and treatment of the enrollee's condition;

e. professional and ancillary services, including those of other trained staff, necessary for patient care and treatment, including diagnostic examinations;

f. individual and group therapy;

g. counseling for family members;

h. electroshock therapy for a mental health patient, when administered by, or under the supervision of, a physician and anesthesia for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy; and

i. supplies and use of equipment required for detoxification or rehabilitation of substance abuse patients.

4. Psychological testing is covered when administered by a panel psychologist, medically indicated, approved by the CRO and directly related to the organic medical or functional condition or when it has an integral role in rehabilitative or psychiatric treatment programs.

5. Coverage for medical care for the treatment of mental disorders is limited to (i) individual psychotherapeutic treatment, (ii) family counseling for the enrollee's family, (iii) group psychotherapeutic treatment, (iv) psychological testing when prescribed or performed by a physician, and (v) electroshock therapy and anesthesia for electroshock therapy.

B. Skilled Nursing Facility Care (Mental Health Only)

1. Mental health care in a skilled nursing facility is subject to the benefit period set forth in App. B, II.B.3.

2. Coverage includes services as described in A.3., above, and medical care. Medical care in a skilled nursing facility is limited to a maximum of two physician visits per week.

C. Halfway House Care (Substance Abuse Only)

1. Substance abuse care in a halfway house is subject to the benefit maximum set forth in App. B, II.B.5.

2. Coverage includes the following halfway house services when provided and billed by the facility:

   a. bed and board;

   b. intake evaluation;

   c. up to one routine drug screen per week;

   d. individual and group therapy or counseling; and

   e. counseling for family members.

D. Partial Hospitalization Care (Mental Health and Substance Abuse)

1. Mental health and substance abuse care in partial hospitalization care treatment facilities is subject to the benefit period set forth in App. B, II.B.2.

2. Inpatient services by non-panel providers are subject to the provisions of Sections IV.B.2. (for mental health treatment) and IV.B.4. (for substance abuse treatment) of this Appendix.

3. Coverage for treatment in a partial hospitalization care treatment facility includes the following services when provided and billed by the facility:

   a. laboratory examinations related to the treatment received in the facility;

   b. prescribed drugs, biologicals, solutions and supplies related to the treatment received, including, for substance abuse, drugs to be taken home;

   c. supplies and use of equipment required in the care of the enrollee's condition;

   d. professional and ancillary services including those of other trained staff, necessary for the treatment of ambulatory

enrollees, including diagnostic examinations;

e. individual and group therapy;

f. psychological testing;

g. counseling for family members;

h. electroshock therapy for a mental health patient when administered by, or under the supervision of, a physician and anesthesia for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy; and

i. an enrollee admitted to partial hospitalization treatment also is entitled to a semiprivate room, general nursing services, meals and special diets.

E. Outpatient Care (Mental Health and Substance Abuse)

1. Outpatient mental health and substance abuse treatment is subject to the benefit maximums set forth in App. B, II.B.4.a. and b.

2. Covered outpatient mental health and substance abuse treatment includes the following:

a. Services provided and billed by facilities

(1) professional and other staff and ancillary services made available by facilities to ambulatory patients;

(2) prescribed drugs and medications dispensed by a facility in connection with treatment received at the facility; and

(3) electroshock therapy for a mental health patient, when administered by, or under the supervision of, a physician and anesthesia for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy.

b. Services provided and billed by facilities or professional providers

(1) Individual psychotherapeutic treatments of a duration of 20 minutes or more (all sessions with a given provider on a single day, with a total duration of four hours or less, shall constitute a single "visit" and be reimbursed as a single unit of service).

(a) Benefits will be paid as set forth in App. B, II.B.4.a. for outpatient mental health services at 100% of the panel reimbursement amount for the first 20 outpatient mental health treatments and 75% for the next 15 treatments per calendar year when provided by panel providers. Services rendered by non-panel providers as provided in App. B, II.A.3.b. and in App. B, IV.B.3. shall be covered up to the benefit maximums. Otherwise, when outpatient mental health services are received from a non-panel provider, without referral by the CRO, such services must be rendered by qualified physicians or qualified facilities, and will be reimbursed at 50% of the amount payable to panel providers for comparable services. Such reimbursement will be made only to the primary enrollee.

(b) Benefits will be paid as set forth in App. B, II.B.4.b. for individual outpatient substance abuse treatment at 100% of the panel reimbursement amount for 35 visits per calendar year when provided by panel providers. No benefits are payable for treatment by non-panel providers, except when services

are rendered by non-panel providers as provided in App. B, II.A.3.b. in which case such treatment shall be covered up to the benefit maximum.

(2) Group mental health and substance abuse treatment is covered subject to the payment provisions in subsections (a) or (b) above.

(3) Family counseling to members of the patient's family is covered subject to the payment provisions in subsections (a) or (b) above.

3. Outpatient psychological testing is covered only when preauthorized by the CRO and performed by a panel provider. Such testing is not considered treatment and therefore is not subject to the benefit period maximum.

IV. Limitations and Exclusions

A. Panel providers are required to contact the CRO to verify eligibility and receive prior authorization of all non-emergency inpatient and outpatient mental health and substance abuse services.

B. Coverage will be limited to the following when rendered by or through non-panel providers:

1. Emergency services. Providers must contact the CRO within 24 hours of the inpatient admission or outpatient treatment for authorization of such services.

2. Non-emergency services. Benefits for mental health services provided by qualified physicians or facilities who/which are non-panel providers are limited to 50% of the panel reimbursement amount unless the enrollee is referred to the non-panel physician or facility by a panel provider. The carrier will make payment to the primary enrollee. Payment to the provider, including any balance, is the responsibility of the enrollee.

3. Outpatient services. Services provided by non-panel physicians (e.g., internists or general practitioners) must be registered with the CRO

after the first visit and are limited to a maximum of one visit.

4. Substance abuse treatment. Coverage for substance abuse treatment does not include services provided by non-panel providers except for emergency detoxification.

C. Coverage is not available for services for treatment of mental disorders which, according to generally accepted medical standards (as determined by the carrier), are not amenable to favorable modification, except that coverage is available for the period necessary to determine that the disorder is not amenable to favorable modification, or for the period necessary for the evaluation and diagnosis of mental deficiency or retardation.

D. Coverage for substance abuse treatment does not include professional services such as dispensing methadone, testing urine specimens, or performing physical or x-ray examinations or other diagnostic procedures unless therapy, counseling or psychological testing are provided on the same day.

E. Coverage does not include family counseling which is rendered by a provider other than the provider for the family member in the course of treatment. Furthermore, reimbursement will be provided only in conjunction with services rendered on behalf of enrollees covered under the General Motors Health Care Program.

F. Coverage does not include diversional therapy.

G. Coverage does not include psychological testing if used as part of, or in connection with, vocational guidance, training or counseling.

H. Coverage under this Appendix does not include treatment of tobacco use disorder (ICD-9 Code 305.1) or treatment of non-dependent abuse of substances such as laxatives, patent medicinals, etc. (ICD-9 Code 305.9).

I. General Limitations and Exclusions under Section IV. and subsections II.C., E., G., and H. of the Terms and Conditions of Appendix A are equally applicable under this Appendix.